U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 09 July 2004

In the Matter of:

NOAH S. SMITH,
Claimant,

v.

CLINCHFIELD COAL CO.,
Employer

and

PITTSTON COAL CO.,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Case No.: 2003-BLA-6210

Appearances:

Joseph E. Wolfe, Esq.
Wolfe, Williams and Rutherford
Norton, Virginia
For the Claimant

H. Ashby Dickerson, Esq.
Penn Stuart
Grundy, Virginia
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits filed under the Black Lung Benefits Act, 30 U.S.C. § 901 et. seq. The Act and implementing regulations, 20 C.F.R. Parts 410, 718, 725,

and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 C.F.R. § 718.201 (2003). In this case, the Claimant, Noah S. Smith, alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on November 4, 2003 in Abingdon, Virginia. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 C.F.R. Part 18 (2003). At the hearing, Director's Exhibits ("DX") 1–45, Claimant's Exhibit ("CX") 1, and Employer's Exhibits ("EX") 1–5 were admitted into evidence without objection.[1] Tr. 6, 9, 11. The Employer submitted a closing argument on December 19, 2003. The Claimant did not submit a closing argument or brief.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits, the testimony at hearing, and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed an initial claim for benefits on July 9, 1981, which was denied by the District Director, Office of Workers' Compensation Programs ("OWCP") on October 19, 1981. The District Director determined that the Claimant was not entitled to benefits. *See* DX 2. The associated file for this claim was apparently never located and is not part of the present case file. *See* DX 1.

The Claimant filed a second claim for benefits on January 12, 1998. In a notice of Initial Finding dated July 7, 1998, the District Director, OWCP awarded benefits. After the submission of additional evidence by the Employer, however, the District Director denied benefits on November 27, 1998, finding that the Claimant had established no elements of entitlement. Again, further evidence was submitted. The District Director again denied the claim on January 12, 1999. The Claimant requested a formal hearing in a letter dated January 28, 1999. An informal conference was held on April 8, 1999. In a Proposed Decision and Order Memorandum of Conference issued on April 20, 1999, the District Director determined that the Claimant did not have pneumoconiosis arising from coal mine employment, nor did he have a total pulmonary disability arising from pneumoconiosis, nor had he shown a material change in condition for duplicate claim purposes. However, the District Director specifically noted that the medical evidence did establish the presence of a total pulmonary or respiratory disability, as the pulmonary function tests met the standard for disability. No further action was taken on the claim. DX 2.

[1] After the hearing, an indexed copy of CX 1 was substituted with the acquiescence of the Employer. *See* the letter to the ALJ from the Employer's counsel dated November 7, 2003.

The Claimant filed the current claim on April 12, 2002. DX 4. The District Director awarded benefits in a Proposed Decision and Order issued on March 12, 2003. DX 36. The Employer requested a hearing on April 3, 2003. DX 38. The claim was referred to the Office of Administrative Law Judges on June 24, 2003. DX 44, DX 45. Before the hearing, the Employer filed a motion to dismiss the claim, or in the alternative, to compel a medical examination and continue the hearing, which I denied by order dated October 21, 2003. The Employer renewed the motion at the close of the hearing, and I again denied it. Tr. 26-27.

APPLICABLE STANDARDS

This claim relates to a "subsequent" claim filed on April 12, 2002. Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2003), as amended at 68 Fed. Reg. 69935 (2003). Pursuant to 20 C.F.R. § 725.309(d) (2003), in order to establish that he is entitled to benefits, the Claimant must demonstrate that "one of the applicable conditions of entitlement … has changed since the date upon which the order denying the prior claim became final" such that he now meets the requirements for entitlement to benefits under 20 C.F.R. Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 C.F.R. §§ 718.1, 718.202, 718.203 and 718.204 (2003). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that the Claimant is entitled to benefits. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996).

ISSUES

The issues contested by the Employer are:

1.) Whether Mr. Smith has pneumoconiosis as defined by the Act and the regulations.

2.) Whether his pneumoconiosis arose out of coal mine employment.

3.) Whether he is totally disabled.

4.) Whether his total disability is due to pneumoconiosis.

5.) Whether he has established a change in condition pursuant to § 725.309(d).

The Employer waived other issues raised in the CM-1025, agreeing at hearing that the claim was timely, that the Claimant had established 22 years of coal mine employment, and that the Claimant's wife is his only dependent. DX 44; Tr. 5–6. The Employer reserved the right to challenge the regulations. DX 38, DX 44, Tr. 6.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Testimony

Mr. Smith did not testify at the hearing because of his poor health. He was born in 1939, and was 64 years old at the time of the hearing. He married his wife, Betty, in 1942, and remains married. Mrs. Smith is his only dependent. DX 1, DX 10.

Mr. Smith's daughter testified that her father is in poor health and must use oxygen all the time. Tr. 13. She described that her father as completely dependent on her mother for all of his daily care. Tr. 15. She stated that her father smoked for much of his life, but quit in recent years. He uses a wheelchair, is mostly bedfast, and cannot move across the room on his own. Tr. 22–24, 25.

The parties agree that Mr. Smith has established 22 years of coal mine employment. Tr. 5, DX 44. Mr. Smith's last coal mine employment took place in Virginia. Therefore, the law of the Fourth Circuit governs this claim. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

Change in Conditions

In a subsequent claim, the threshold issue is whether one of the applicable conditions of entitlement has changed since the previous claim was denied. Mr. Smith's previous claim was denied because he failed to establish that he had pneumoconiosis. For the reasons given below, I find that the medical opinions given by Dr. Forehand and Dr. Robinette in connection with the current claim establish that Mr. Smith has pneumoconiosis. Because the new evidence establishes that a material change in conditions has occurred, I must consider all of the evidence in the record in reaching my decision whether he is now entitled to benefits. *Lisa Lee Mines v. Director, OWCP*, 57 F.3d 402, 406 (4th Cir. 1995). Evidence admitted in the prior claim may be considered notwithstanding the limitations on the introduction of evidence contained in 20 CFR § 725.414 (2003). *See* 20 CFR § 725.309(d)(1) (2003), which provides, "Any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim."

Medical Evidence

Chest X-rays

Chest X-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case. X-ray interpretations submitted by the parties in connection with the current claim in accordance with the limitations contained in 20 CFR § 725.414 (2003) appear in bold print.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs.

Small opacities (1, 2, or 3) (in ascending order of profusion) may be classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B, or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b) (2003). Any such readings are therefore included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physician qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of A and B-readers issued by the National Institute of Occupational Safety and Health (NIOSH),[2] and the lists of board-certified physicians maintained by The American Board of Medical Specialties.[3] If no qualifications are noted for any of the following physicians, it means that I have been unable to ascertain them either from the record or the NIOSH list. Qualifications of physicians are abbreviated as follows: A = NIOSH certified A-reader; B = NIOSH certified B-reader; BCR = Board-certified in radiology. Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n.16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative For Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
01/17/79	DX 2 Per NIOSH, an unidentified physician "qualified under the Act" found Category 1 pneumoconiosis	DX 2 Renn (B)	
02/17/98	DX 2 Forehand (B) 1/0, A DX 2 Navani (BCR, B) 1/1, 0 DX 2 DePonte (BCR, B) 1/0, A	**EX 1 Dahhan (B)** DX 2 Sargent (BCR, B) 0/1, 0 (2 readings) DX 2 Fino (B) DX 2 Scott (BCR, B) DX 2 Wheeler (BCR, B)	

[2]NIOSH is the federal government agency which certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as A-readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as B-readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. In this case, to determine the credentials of Drs. Coburn, Humphreys and Mullens, I referred to the U.S. Department of Health and Human Services, List of NIOSH Approved B Readers with Inclusive Dates of Approval [as of] June 7, 2004, found at <http://www.oalj.dol.gov/public/blalung/refrnc/bread3_07_04.htm>

[3]On June 25, 2004, I visited the web-site found at <http://www.abms.org.> to determine the board certification credentials of Drs. Coburn, Humphreys and Mullens.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative For Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
04/01/98		DX 2 Fino (B) DX 2 Scott (BCR, B) DX 2 Wheeler (BCR, B)	
06/15/98		DX 2 Fino (B) DX 2 Scott (BCR, B) DX 2 Wheeler (BCR, B)	
09/16/98		DX 2 Hippensteel (B) 0/1 DX 2 Fino (B) DX 2 Wheeler (BCR, B) DX 2 Scott (BCR, B)	
10/22/98		DX 2 Fino (B) DX 2 Scott (BCR, B) DX 2 Wheeler (BCR, B)	DX 12 Mullens (BCR) COPD with bilateral upper lobe parenchymal scarring.
11/17/98	DX 2 DePonte (BCR, B) 1/0, A		
02/22/99			DX 12 Humphreys (BCR) COPD and bilateral upper lobe parenchymal scarring. Old granulomatous disease.
08/22/99			DX 12 Humphreys (BCR) COPD and bilateral upper lobe parenchymal scarring. Old granulomatous disease.
08/23/99			DX 12 Coburn (BCR, B) Chronic obstructive disease with linear stranding in the right apex. Also evidence of old granulomatous disease.
08/04/00			DX 12 Coburn (BCR, B) Chronic obstructive disease with chronic interstitial changes. Also evidence of old granulomatous disease
06/09/01	**DX 12 DePonte (BCR, B) 1/0, A**		
09/05/02	**DX 13 Forehand (B) 1/0, A**	**DX 34 Hippensteel (B)**	DX 14 Navani (BCR, B) Read for quality only Film quality 2
11/07/02		**DX 34 Wheeler (BCR, B) 0/1**	

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-33–1-34 (1991). Mr. Smith had three CT scans, on April 3, 1998, September 16, 1998, and June 19, 2002. The radiologist gave the following impression from the April 1998 CT scan:

> 1. Stellate lesion LUL [left upper lobe] and right perihilar region. Though neoplastic process cannot definitely be excluded, findings are most suggestive of parenchymal scarring. …
>
> 2. Old granulomatous disease.
>
> 3. Noncalcified pulmonary nodules right lung which may represent noncalcified granulomas
>
> 4. Pulmonary hyperinflation consistent with obstructive airway disease.
>
> 5. Small water density lesions of approximately 1.6 cm in diameter suggestive of benign hepatic cysts.

DX 12. The radiologists' reports for the September 1998 and June 2002 CT scans are not in the record.

Mr. Smith's treating physician, Dr. Robinette, interpreted the April 1998 and June 2002 scans to show massive progressive fibrosis, i.e., complicated pneumoconiosis. CX 1. There is no indication that Dr. Robinette ever saw the September 1998 CT scan, taken during an examination by Dr. Hippensteel on behalf of the Employer.

Dr. Wheeler and Dr. Scott, who reviewed the April 1998 CT scan on behalf of the Employer in connection with the 1998 claim, interpreted it to show healed tuberculosis. Dr. Fino, DX 2, who also reviewed the April 1998 scan on behalf of the Employer in connection with the 1998 claim, said it showed calcified granulomatous changes consistent with previous fungal or tuberculous changes, but not a coal mine dust related disease. Dr. Scott also interpreted the September 1998 scan to show healed TB and emphysema, and relatively large proximal pulmonary arteries indicated possible pulmonary hypertension. DX 2. Dr. Hippensteel, who reviewed all three CT scans on behalf of the Employer, interpreted them to show granulomatous disease. DX 2, EX 2, EX 5.

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of

ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1), and maximum voluntary ventilation (MVV). The following chart summarizes the results of the pulmonary function studies available in this case. Pulmonary function studies submitted by the parties in connection with the current claim in accordance with the limitations contained in 20 CFR § 725.414 (2003) appear in bold print. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 C.F.R. § 718.203(b)(2)(i) (2003).

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 2 02/17/98 Forehand	58 72"	1.09 1.14	2.72 3.16	40% 36%	36 34	Yes Yes	Obstructive ventilatory pattern. Acceptable test per Dr. Michos, who noted suboptimal MVV performance.
DX 2 09/16/98 Hippensteel	59 72"	1.00 1.15	3.08 3.54	32% 33%	42 37	Yes Yes	Severe obstruction with some improvement post bronchodilator
DX 12, CX 1 08/07/00 Robinette	**61 71"** [4]	**.79 .82**	**2.31 2.44**	**34% 34%**	**--- ---**	**Yes Yes**	**Very severe obstructive lung disease with components of restriction.**
CX 1 10/10/01 Robinette	**62 71"**	**.70 .73**	**2.39 2.64**	**29% 28%**	**--- ---**	**Yes Yes**	**Very severe obstructive lung disease without response to bronchodilator therapy.**

[4] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner from 71" to 72", I have taken the mid-point (71.5") in determining whether the studies qualify to show disability under the regulations. All of the tests are qualifying to show disability whether considering the mid-point, or the heights listed by the persons who administered the testing.

Arterial Blood Gas Studies

Arterial blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial blood oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (pO_2) and the percentage of carbon dioxide (pCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The following chart summarizes the arterial blood gas studies available in this case. Arterial blood gas studies submitted by the parties in connection with the current claim in accordance with the limitations contained in 20 CFR § 725.414 (2003) appear in bold print. A "qualifying" arterial gas study yields values that are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b) (2003).

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify?	Physician Impression
DX 2	02/17/98	Forehand	42 45	57 45	Yes Yes	Hypoxemia at rest and with exercise. Technically acceptable study per Dr. Michos.
DX 2	09/16/98	Hippensteel	49.1	59	Yes	Moderate hypoxemia with hypercarbia at rest
DX 12, CX 1	**08/07/00**	**Robinette**	**52**	**59**	**Yes**	**Relative hypercapnia and intercurrent hypoxemia.**
DX 13	**09/05/02**	**Forehand**	**52**	**72**	**Yes**	**Carbon dioxide retention. Acceptable study per Dr. Michos**
DX 34	**11/07/02**	**Hippensteel**	**53.6**	**95.5**	**Yes**	**Significant gas exchange impairment with chronic CO_2 retention and elevated A/a gradient. Carboxy-hemoglobin level is normal.**

Medical Opinions

Medical opinions are relevant to the issues of whether a miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability.

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 C.F.R. § 718.202(a)(4) (2003). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 C.F.R. § 718.202(a)(4) (2003). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 C.F.R. § 718.204(c)(2) (2003). The record contains the following medical opinions submitted in connection with the current claim.

On November 2, 1992, Mr. Smith visited Dr. Martin Monahan, an internist, to be cleared for cataract surgery. As part of the examination, Mr. Smith reported to Dr. Monahan that he did not "have as much breath as he should." He said he had quit smoking the previous month, having smoked more than a pack a day for about 20 years. On physical examination, his lungs were clear. His EKG raised the possibility of an old myocardial infarction, but was unchanged from November 1989 except for some premature ventricular contractions, and there was no definite evidence of heart disease. Clinically, he had some slight chronic obstructive pulmonary disease. DX 2, DX 12, CX 1, pp. 62, 64-65.

On February 17, 1998, Dr. J. Randolph Forehand examined Mr. Smith on behalf of the Department of Labor. Dr. Forehand is Board-certified in Pediatric Medicine, and Allergy and Immunology, and a B-reader. He is Board-eligible in Pediatric Pulmonary Medicine. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He read the x-ray as showing complicated pneumoconiosis. The pulmonary function test showed an obstructive ventilatory pattern. The arterial blood gas study revealed hypoxemia at rest and with exercise. Dr. Forehand concluded that Mr. Smith had coal workers pneumoconiosis based on his history, pulmonary function study, arterial blood gas, chest x-ray and physical examination; he also diagnosed chronic bronchitis based on the physical examination, pulmonary function study and arterial blood gas. He attributed the diagnoses to coal dust exposure for 17 years, and cigarette smoke for 15 years. As to the degree of severity of the impairment, Dr. Forehand concluded:

> Notable respiratory impairments are present. Insufficient residual ventilatory and gas exchange capacity remains to continue working in last coal mining job. Cannot return to work. Totally and permanently disabled.

As to the extent to which each of the diagnoses listed contributed to the impairment, he said:

> The appearance of the chest x-ray is indicative of significant coal dust exposure and lung injury and implies that CWP [coal workers' pneumoconiosis] is a major contributing factor. 15 years of smoking cigarettes may also contribute to impairment.

Dr. Forehand recommended that Mr. Smith be referred to another physician to follow up the chest x-ray. DX 2.

On March 30, 1998, at the request of the Department of Labor, Dr. John A. Michos, who is board-certified in Internal Medicine and Pulmonary Disease, reviewed interpretations of the x-ray taken February 17, 1998, by Dr. Forehand (positive for simple and complicated pneumoconiosis) and Dr. Sargent (negative for pneumoconiosis), along with Dr. Forehand's report of his examination of Mr. Smith. Dr. Sargent's x-ray interpretation suggested the possibility of granulomatous disease or tuberculosis as the cause of the abnormalities on the x-ray. Dr. Michos said that insufficient and conflicting medical evidence had been provided to establish a diagnosis of coal workers' pneumoconiosis. Dr. Michos said if complicated pneumoconiosis was established by other board certified, B reading radiologists, and not secondary to another etiology such as active TB or malignancy from lung cancer, then benefits should be assigned. DX 2.

Dr. Emory Robinette has treated Mr. Smith since 1998, on referral from Dr. Forehand because of the abnormal chest x-ray taken in connection with the black lung evaluation for the Department of Labor. Dr. Robinette is Board-certified in Internal Medicine and Pulmonary Disease, and a B-reader. His treatment records in evidence include records of hospitalizations, clinical testing, chest x-rays, and his own office notes, and the records of the 1992 visit to Dr. Monahan, described above. Dr. Monahan practices with Dr. Robinette. DX 2, DX 12, CX 1.

Dr. Robinette reported the results of his initial examination of Mr. Smith to Dr. Forehand on April 2, 1998. Mr. Smith's only constitutional symptom was weight loss from 165 to 152 pounds. He had a chronic cough, and mild to moderate dyspnea. PPD's in the past were negative, and he had not been exposed to tuberculosis. On physical examination, his chest had an increased AP diameter. Breath sounds were diminished, and there were bilateral expiratory wheezes, and moderate prolongation of the expiratory phase. Chest x-ray taken April 1 showed infiltrate with atelectasis in the right upper lobe. Differential diagnosis included possible atypical infection such as Mycobacterium tuberculosis versus bronchogenic carcinoma and compression of a bronchus with focal atelectasis affecting the right upper lobe. Dr. Robinette recommended additional tests, including a CT scan, and repeated the PPD. A handwritten note at the bottom of the letter noted that the CT scan was "markedly abnormal." DX 2, DX 12, CX 1, p. 59.

On April 10, 1998, Mr. Smith underwent a bronchoscopy. The indications were listed as nodular lesions in the right upper lobe with evidence of fibrotic stranding, nodular lesion in the left upper lobe with possible mass-type effect. Bronchial washings were obtained from the nodular densities in the right upper lobe. Dr. Robinette was unable to identify the nodular lesion identified by CT scan in the left upper lobe. CX 1 , p. 60. Dr. Robinette reported the results to Mr. Smith on April 16, and recommended treatment of Streptococcus pneumonia and Branhamella Catarrhalis identified from culture after the bronchoscopy. DX 2, DX 12, CX 1, p. 63.

Mr. Smith returned to Dr. Robinette for follow-up of his "underlying black lung disease with an area of progressive massive fibrosis" on June 15, 1998. Sputum and bronchial washing culture reports were negative for tuberculosis. Dr. Robinette reported that the bronchoscopy findings

were felt to be consistent with areas of progressive massive fibrosis.[5] Biopsies were nondiagnostic for malignancy. Culture and sensitivity was negative for atypical Mycobacterium. He did, however, grow Streptococcus pneumoniae as well as Branhamella Catarrhalis.

A chest x-ray did not show progression since the previous on taken April 1, suggesting either a benign process or a very slow growing neoplasm if neoplasm. Dr. Robinette suggested a follow-up x-ray in four months. DX 2, DX 12, CX 1, p. 57. From this point on, Dr. Robinette's records consistently identify Mr. Smith's diagnoses as black lung disease and progressive massive fibrosis, occasionally also referring to pulmonary emphysema, chronic airflow obstruction, bronchitis, and intercurrent hypoxemia.

Dr. Kirk E. Hippensteel examined Mr. Smith on behalf of the Employer on September 16, 1998. Dr. Hippensteel is Board-certified in Internal Medicine and Pulmonary Disease, and Critical Care Medicine, and a B-reader. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, CT scan, blood gas study and pulmonary function testing. He read the x-ray as showing a few noncalcified densities in upper lobes, 0/1, associated with calcified granulomas which may relate to old granulomatous disease, and bullous disease. CT scan also showed calcified and noncalcified nodules in both upper lobes with pleural inflammation, also most likely related to granulomatous disease. The pulmonary function test showed severe obstruction with some improvement post bronchodilator. His MVV was severely decreased. Lung volumes showed mild air trapping with no restriction. He could not perform a diffusion test. The arterial blood gas study revealed hypoxemia with hypercarbia at rest, and elevated carboxyhemoglobin consistent with smoking a pack per day of cigarettes. He also reviewed medical records, including Dr. Forehand's report of his February 1998 examination, Dr. Michos' March 1998 report of his limited record review, and a NIOSH report dated September 17, 1979, stating Mr. Smith had an x-ray consistent with category 1 simple pneumoconiosis. Dr. Hippensteel concluded that he disagreed with Dr. Forehand's interpretation of his x-ray, and that Dr. Forehand failed to consider some diagnoses as a cause for the abnormalities. He said that although the cause was not clear from the records, Mr. Smith had granulomatous disease which accounted for the x-ray abnormalities, and did not have complicated pneumoconiosis, nor enough abnormalities to diagnose simple pneumoconiosis. He said Mr. Smith's impairment was not typical for coal workers' pneumoconiosis, but was a partially reversible, purely obstructive lung disease consistent with impairment from cigarette smoking, bullous emphysema, and possibly added to by allergies, but not caused by either pneumoconiosis or granulomatous disease. DX 2.

On October 22, 1998, Mr. Smith complained to Dr. Robinette of some cough and congestion. His weight was up to 151, a four-pound gain. DX 2, CX 1, p. 56.

[5] The Employer argued in its Closing Argument at p. 16 that Dr. Robinette failed to explain why he believed the findings from the bronchoscopy to be consistent with pneumoconiosis. I find that a fair reading of Dr. Robinette's reports and treatment records support the conclusion that he did so because the tests he performed ruled out a malignancy and tuberculosis.

Dr. Michos reviewed additional evidence for the Department of labor, including x-ray interpretations by Drs. Navani, Scott, Wheeler and Renn, the CT scan interpretation by Dr. Scott, and Dr. Hippensteel's report of his examination of September 29, 1998, and concluded in his report dated November 9, 1998, that Mr. Smith did not have pneumoconiosis and that his total respiratory disability "may be secondary to continuous tobacco exposure, given the lack of significant radiographic abnormalities. Typically, simple CWP is not associated with clinically significant symptoms, whereas continuous cigarette abuse ore exposure is well known to account for the claimant's symptoms and findings." DX 2. However, review of the list of items he reviewed contained in his report discloses that he did not have much of the evidence eventually relied on by the Claimant to establish complicated pneumoconiosis, e.g., Dr. DePonte's reading of the February 17, 1998, x-ray diagnosing complicated pneumoconiosis, or any of Dr. Robinette's records. I find that this opinion was based on incomplete and one-sided evidence, and will give it no weight.

Mr. Smith returned to Dr. Robinette for follow-up on February 22, 1999. At that time he was doing "satisfactory." His weight was up two more pounds. DX 12, CX 1, p. 55.

Mr. Smith saw Dr. Robinette again on August 23, 1999. He was dyspneic on exertion, and had chronic cough and congestion. Dr. Robinette compared x-rays from April 1, 1998 and August 23, 1999, and stated there was no significant interval change. Mr. Smith's "clinical presentation [was] compatible with progressive massive fibrosis and coal workers' pneumoconiosis." DX 12, CX 1, p. 54.

In an office record from February 21, 2000, Dr. Robinette said,

> Because of an elevated carboxyhemoglobin level I discussed the importance of absolute smoking cessation in the face of advancing lung disease with associated airflow obstruction and progressive massive fibrosis. I urged him to use alternate forms of tobacco other than smoking. …

DX 12, CX 1, p. 53.

On August 7, 2000, Mr. Smith underwent pulmonary function and blood gas studies interpreted by Dr. Robinette during an office visit. Mr. Smith was still smoking a few cigarettes a day. The studies were compatible with very severe obstructive airways disease with evidence of marked impairment of diffusion capacity, hypoxemia and hypercapnia. Chest x-ray showed evidence of pleural parenchymal scarring. There was evidence of diffuse interstitial fibrosis and a density in the left lung base probably associated with a parenchymal scar. There was marked emphysema present and pulmonary hypertension. Dr. Robinette

> advised Mr. Smith that he has advanced lung disease consistent with underlying black lung, pulmonary hypertension, severe COPD and has evidence of hypoxemia and hypercapnia. I strongly urged him to quit smoking, use his medication on regular basis …

Mr. Smith was to return in six months, or earlier if needed. DX 12, CX 1, pp. 45-46.

In an April 11, 2001 office record, Dr. Robinette said Mr. Smith had "an occupational pneumoconiosis with an area of progressive massive fibrosis in his right upper lobe attributable to his prior coal mining employment." He also concluded, "He is disabled from working as an underground coal miner based on his functional assessment and his radiographic abnormalities." DX 12, CX 1, p. 44.

In a letter to Claimant's counsel dated April 24, 2001, Dr. Robinette wrote, "Mr. Noah Smith has evidence of complicated pneumoconiosis with a severe respiratory impairment and his short-term survival is poor." DX 12.

Mr. Smith underwent pulmonary function testing on October 10, 2001, and visited Dr. Robinette on November 8, 2001. Dr. Robinette said that pulmonary function studies demonstrated a severe obstructive defect without response to bronchodilator therapy. Lung function compared to August of 2000 was about the same. He planned to see Mr. Smith again in six months. CX 1, pp. 41-42.

Dr. Robinette saw Mr. Smith in follow-up on April 3 and May 16, 2002. By April 2002, he was using supplemental oxygen. CX 1, p. 36. On May 16, Dr. Robinette said Mr. Smith was

> having profound dyspnea on minimal exertional activity, chronic cough, congestion and shortness of breath. Obviously his condition has deteriorated. He currently weighs 139 pounds and appears to be emaciated as a consequence of his severe pulmonary disease.

CX 1, p. 35.

Mr. Smith was hospitalized at the Johnston Memorial Hospital from June 18-21, 2002, for breathing problems. Dr. Robinette recounted that he originally saw Mr. Smith on the request of Dr. Forehand in 1998, about a year after Mr. Smith left the mines, and that chest x-ray and CT scan were "compatible with complicated coal workers' pneumoconiosis with stellate lesions in areas of progressive massive fibrosis." CX 1 at 31. The discharge summary indicates that he had "[r]espiratory failure due to Haemophilus influenzae pneumonitis," and "complicated coal workers' pneumoconiosis with underlying progressive massive fibrosis." A repeat CT scan

> showed evidence of pneumoconiotic nodules in the right upper lung with progressive massive fibrosis right greater than left. There is underlying chronic obstructive pulmonary disease, chronic interstitial fibrosis … and granulomatous disease …

CX 1 at 32.

Mr. Smith returned to Dr. Robinette's office for follow-up on July 22 and August 16, 2002. During the later visit, Mr. Smith complained of progressive early satiety, dyspnea, chronic cough and congestion. He was profoundly weak. CX 1 at 25.

Mr. Smith was hospitalized again from August 18-22, 2002 for "severe, profound dyspnea." His discharge diagnoses were: pneumonia secondary to Providencia stuartii,

complicated coal workers' pneumoconiosis with progressive massive fibrosis, progressive weight loss secondary to end stage lung disease, very severe chronic obstructive pulmonary disease. DX 12, CX 1 at 29.

Dr. Forehand examined Mr. Smith on behalf of the Department of Labor a second time on September 5, 2002, in connection with the current claim. He again took occupational, medical, and social histories and administered chest x-ray and arterial blood gas testing. He also recorded Claimant's subjective complaints. He recorded Mr. Smith's coal mine employment history as totaling approximately 25 years. Dr. Forehand also noted that Mr. Smith smoked 1 pack of cigarettes a day for about 20 years from 1982 to 2002. Dr. Forehand noted that upon physical examination he heard "crackles" throughout the chest and he noted that a pulmonary function test was "medically contraindicated." Arterial blood gases showed carbon dioxide retention. He concluded that Mr. Smith had chronic bronchitis based on history, and coal workers' pneumoconiosis based on the x-ray and the arterial blood gas study. He attributed these conditions to cigarette smoking and coal dust exposure. He also wrote that "a significant respiratory impairment is present. Insufficient residual oxygen-transport capacity remains to continue in last coal mining job. Unable to work totally and permanently disabled." He attributed this total disability to chronic bronchitis and coal workers' pneumoconiosis, and that both "combine to impair lung function." He further wrote: "the pattern of disability indicative of the important role played by coal workers' pneumoconiosis in impairing lung function." DX 13.

After Dr. Forehand's examination, Mr. Smith was again hospitalized under Dr. Robinette's care from September 6-13, 2002, for heart arrhythmias. Dr. Robinette recorded in the admitting notes that Dr. Forehand had referred Mr. Smith to the emergency room because of a supraventricular arrhythmia with a heart rate of about 170. Dr. Robinette recited the following history:

> … Mr. Smith has been followed by my office since 1998 for his underlying black lung disease with severe airflow obstruction. At the time of my initial evaluation, he was found to have a markedly abnormal chest x-ray with associated weight loss. A CT scan of the thorax confirmed evidence of bilateral and apical pleural _____, a 1.6 cm stellate density in the left upper lobe, and a 2 cm stellate density in the right perihilar region with evidence of superimposed interstitial fibrosis. … Radiographic findings were felt to be compatible with complicated coal workers' pneumoconiosis and progressive massive fibrosis. A PPD was placed and was negative. … His recent history has been complicated by two prior admissions in June and in August of 2002 [for acute exacerbation of his lung disease] … Oxygen saturation on supplemental oxygen at 2 liters per minute was only 88%. Inspired oxygen concentration was increased to 3 liters per minute. He was discharged from the hospital on oral antibiotics and has since been seen in the office for follow up. There had been some clinical response, but it is generally felt that the patient has progressive weight loss due to end stage lung disease associated with underlying complicated coal workers' pneumoconiosis with progressive massive fibrosis.

CX 1 at 20. The discharge diagnoses were: atrial flutter/fibrillation with rapid ventricular response, improved; CWP with progressive massive fibrosis, progressive weight loss, chronic

hypoxemia secondary to end stage lung disease due to black lung. Dr. Robinette added the following comment to the discharge summary:

> In view of the patient's end stage lung disease and complex cardiac arrhythmias, I did not feel that he should be subjected to further diagnostic testing, i.e. pulmonary function studies or exercise testing to evaluate possible occupational pneumoconiosis. This would only serve to exacerbate his complex cardiac arrhythmias, superimposed on severe pulmonary disease due to his intrinsic black lung and progressive massive fibrosis. There is an adequate body of diagnostic studies that document the severity of his pulmonary disease.

CX 1, p. 17. The file contains a handwritten note to on a prescription slip dated September 13, 2002, stating "Noah Smith is physically unable to perform pulmonary function studies or exercise test due to severe pulmonary & cardiac disease." DX 29. Mr. Smith continued seeing Dr. Robinette for follow-up after his release from the hospital, with office visits on October 19, November 15 and December 27, 2002. DX 12, CX 1.

Dr. Hippensteel examined Mr. Smith on behalf of the Employer a second time on November 7, 2002. He took occupational, medical, and social histories and administered a chest x-ray, an arterial blood gas study, but he performed no pulmonary function testing, because Dr. Robinette had written the note recommending against it. He also recorded Claimant's subjective complaints. He recorded Mr. Smith's coal mine employment history as totaling approximately 25 years. Dr. Hippensteel also noted that Mr. Smith smoked 1 pack of cigarettes a day for about 10–12 years, quitting in 2002. Dr. Hippensteel noted that the chest x-ray was read as 0/1 for pneumoconiosis by Dr. Wheeler, and arterial blood gases showed significant gas exchange impairment. An electrocardiogram was quite abnormal. Mr. Smith was unable to lie flat enough to obtain another CT scan. Dr. Hippensteel concluded that Mr. Smith has "severe cardiac and pulmonary disease that has affected his gas exchange and ability to exercise and makes him unable to work at any job." He did not diagnose pneumoconiosis. Dr. Hippensteel then also reviewed the medical records including previous x-rays, pulmonary function studies, arterial blood gas studies, and medical reports.[6] He again found that Mr. Smith was unable to perform any work, although he did not diagnose pneumoconiosis. DX 34. In a letter dated December 6, 2002, Dr. Hippensteel reviewed a CT chest scan from Johnston Memorial Hospital dated June 19, 2002. EX 2. He found "no opacities suggestive of coal workers' pneumoconiosis." EX 2, EX 5, p.25–26.

In a deposition taken on October 27, 2003, Dr. Hippensteel reiterated much of what is in his written reports. EX 5. He testified that Mr. Smith had given inconsistent smoking histories, and that the reports given to other doctors of heavier smoking were consistent with a heavy enough smoking history to cause significant lung disease. EX 5, pp. 8-10. He said that increased carbon dioxide as Mr. Smith has, is a finding in people with severe lung disease,

[6] At Dr. Hippensteel's deposition, one of Claimant's attorneys objected that Dr. Hippensteel had relied on x-ray readings which would not be admissible under the limitations in the current regulations. EX 5, pp. 4-5, 22. Counsel was correct; however, his colleague did not object to admission of the report at hearing.

indicative of chronic respiratory failure, more commonly found in people with chronic obstructive pulmonary disease with a significant smoking history than in people with coal workers' pneumoconiosis. EX 5 at 16. He did not believe Mr. Smith had restrictive disease, which he said is usually present when coal workers' pneumoconiosis results in the level of obstructive disease demonstrated by Mr. Smith. He elaborated that the CT scan from June 19, 2002 showed "rounded lesions in both lung fields that were less than one centimeter in diameter that was suggestive of calcified granulomas." EX 5, p.25. In describing this particular CT scan, he stated that:

> [t]he presence of calcified nodules is strongly indicative of granulomatous disease, but they are quite often mixed with non-calcified nodules, rounded opacities in the lungs, and that is how they first show up, and over time, some of them get calcified.
>
> I would note that on that CT scan from 1998, the nodule themselves have defervesced in size since that time, from the time of the 2002 CT scan, which would be against coal workers' pneumoconiosis but would be in favor of a disease process that actually became quiescent and actually became less inflammatory or less inflamed over that period of time.

EX 5, p.48–49. He testified that the testing he did for histoplasmosis, sarcoidosis, and alpha-1-antitrypsin deficiency were inconclusive. EX 5, p.42. Finally, Dr. Hippensteel again concluded that Mr. Smith does have a severe respiratory impairment that disables him. EX 5, p.36. Dr. Hippensteel reiterated, however, that Mr. Smith did not suffer from any chronic lung disease related to coal dust exposure. EX 5, pp.34-36. Dr. Hippensteel testified that the most significant cause of Mr. Smith's disability is his smoking history, but that granulomatous disease and scarring also contributed. EX 5, p. 37. He agreed on cross examination that coal mine dust inhalation can cause a purely obstructive impairment with no restriction, and can combine with smoking to cause emphysema. EX 5, p. 43. He also agreed that it is possible for a person to have coal workers' pneumoconiosis and granulomatous processes at the same time. EX 5, p. 49.

Mr. Smith was hospitalized again on January 29, 2003 for severe dyspnea, cough, and congestion. It was determined that he had an acute exacerbation of his "black lung disease with possible pneumonia." When he was discharged on February 3, 2003, Dr. Robinette's diagnoses were: acute respiratory decompensation secondary to Providencia stuartii with an exacerbation of his underlying black lung; coal workers' pneumoconiosis with underlying progressive massive fibrosis; history of complex atrial arrhythmias; and progressive weight loss. DX 12, CX 1.

The most recent record from Dr. Robinette is an office note dated June 20, 2003. Mr. Smith returned for follow-up of his coal workers' pneumoconiosis with chronic airflow obstruction and history of complex arrhythmias. He had diminished breath sounds with poor air movement, and marked prolongation of the expiratory phase. Dr. Robinette concluded on p.1 of CX 1:

> … Obviously, Mr. Smith has end-stage lung disease superimposed on progressive massive fibrosis and CWP. He is dyspneic even at rest and appears to be chronically and irreversibly ill.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical," pneumoconiosis and statutory, or "legal," pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those disease recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201(2003).

20 C.F.R. § 718.202(a) (2003) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in § 718.304 (irrebuttable presumption of total disability if there is a showing of complicated pneumoconiosis), § 718.305 (not applicable to claims filed after January 1, 1982) or § 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that the Claimant has had a lung biopsy, and, of course, no autopsy has been performed. Two of the three presumptions do not apply, because the Claimant filed his claim after January 1, 1982, and he is still living. There is, however, some evidence of complicated pneumoconiosis. In order to determine whether the evidence establishes the existence of simple or complicated pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to

either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3rd Cir. 1997).

Pursuant to § 718.304(a), the existence of complicated pneumoconiosis may be established when diagnosed by a chest x-ray which yields one or more large opacities (greater than 1 centimeter) and would be classified in Category A, B, or C. X-ray evidence is not the exclusive means of establishing complicated pneumoconiosis under § 718.304. Its existence may also be established under § 718.304(b) by biopsy or autopsy or under § 718.304(c), by an equivalent diagnostic result reached by other means. The Benefits Review Board has held that the Administrative Law Judge must first determine whether the relevant evidence in each category tends to establish the existence of complicated pneumoconiosis and then must weigh together the evidence at each subsection before determining whether invocation of the irrebuttable presumption under § 718.304 has been established. *Melnick v. Consolidated Coal Co.*, 16 B.L.R. 1-31, 1-33 (1991) (en banc). The United States Court of Appeals for the Fourth Circuit has held that "even where some x-ray evidence opacities that would satisfy the requirements of prong (A), if other x-ray evidence is available or if evidence is available that is relevant to an analysis under prong (B) [biopsy or autopsy] or prong (C) [other means] then all the evidence must be considered and evaluated to determine whether the evidence as a whole indicates a condition of such severity that it would produce opacities greater than one centimeter in diameter or an x-ray." *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F.3d 250, 256 (4th Cir. 2000).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314–315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151–152 (1987); *Eastern Associated Coal. Corp. v. Director*, 220 F.3d 250, 258–259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp.*, 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148, 1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319–320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Of the seven x-rays submitted in connection with the first claim, readings of two were in equipoise, i.e., read as positive or negative by similarly qualified readers (January 17, 1979, and February 17, 1998), readings of four by well-qualified readers were only negative (April 1, 1998, June 15, 1998, September 16, 1998 and October 22, 1998), and the reading of one was only positive (November 17, 1998). Thus despite the fact that the last x-ray was read as positive for simple and complicated pneumoconiosis by a dually qualified reader, the weight of the x-ray evidence in the prior claim was negative.

Four x-rays taken in connection with medical treatment, on February 22, 1999, August 22 and 23, 1999, and August 4, 2000, were not read for pneumoconiosis. The radiologists who read them consistently recorded COPD, bilateral upper lobe parenchymal scarring, and old granulomatous disease. Whether an x-ray interpretation which is silent as to pneumoconiosis should be interpreted as negative for pneumoconiosis, is an issue of fact for the ALJ to resolve. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co*., 6 B.L.R. 1-930 (1984). I find that none of these x-rays should be read as negative.

Of the three current x-rays that were actually interpreted for the presence of pneumoconiosis in this case, two have been read by two different reviewers to be positive for complicated pneumoconiosis, and two were read by two different reviewers as completely negative for pneumoconiosis. For cases with conflicting x-ray evidence, the regulations specifically provide,

> Where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 C.F.R. § 718.202(a)(1) (2003); *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213, n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually-qualified physicians. *Scheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *Adkins*, 958 F.2d at 52.

The x-ray taken on June 2, 2001 was read as positive for simple and complicated pneumoconiosis by Dr. DePonte, a board-certified radiologist and B-reader. There are no negative readings. This x-ray is positive.

Dr. Forehand, a B-reader, also read the x-ray taken on September 5, 2002 as positive for simple and complicated pneumoconiosis. Dr. Hippensteel, who is also a B-reader, read it as completely negative for pneumoconiosis. I find that this x-ray is in equipoise.

Finally, Dr. Wheeler, a dually-qualified radiologist, read the most recent x-ray taken on November 7, 2002, as negative, classifying it as 0/1. Because of its classification as 0/1, I find this x-ray to be negative. Nonetheless, Dr. Wheeler reported at the bottom of the form he completed that a "few small nodules could be pneumoconiosis." DX 34.

Taken together, the recent x-ray evidence, which is entitled to more weight, is essentially in equipoise. Thus I find that neither the current x-ray evidence, nor the x-ray evidence taken as a whole, is sufficient to establish the existence of either simple or complicated pneumoconiosis

under § 718.202(a)(1). Similarly, the CT scans have been read as both positive and negative, or only as negative. They, too, are insufficient to establish the existence of pneumoconiosis.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1291, 1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186–187 (6th Cir. 1995); *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him only episodically. *Onderko v. Director, OWCP*, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician. Rather, this is one factor which may be taken into consideration…weighing…the medical evidence." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be given controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 C.F.R. § 718.104(d) (2003).

The physician opinion evidence consists of the opinions of Dr. Forehand, Dr. Robinette (Mr. Smith's treating physician), and Dr. Hippensteel.[7] I do not count Dr. Michos' negative opinion given in November 1998, as it was based on incomplete and one-sided information. Dr.

[7] As this is a subsequent claim, I first considered only the opinions Drs. Robinette, Forehand and Hippensteel gave in connection with the current claim. Having decided that their recent opinions establish a change in conditions, I then considered all of the available evidence from the second and third claims together.

Forehand and Dr. Robinette diagnose Mr. Smith as having coal workers' pneumoconiosis, and complicated pneumoconiosis. Dr. Hippensteel concludes that Mr. Smith does not have pneumoconiosis.

At the outset I note that all three doctors agree that chest x-rays and CT scans show abnormalities in Mr. Smith's lungs, and that he has a total pulmonary or respiratory disability. Their disagreement is only as to the identification of the disease process or processes responsible. All provided reports which are, on their face, "documented" and "reasoned" opinions. However, after considering the conflicting medical opinions, I accord more weight to the opinions of Drs. Robinette and Forehand for the following reasons.

In weighing the opinion of Dr. Robinette, Mr. Smith's treating physician since 1998, the following factors must be considered pursuant to Section 718.104:

(1) *Nature of relationship*. The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;

(2) *Duration of relationship*. The length of the treatment relationship demonstrates whether the physician has observed the miner long enough to obtain a superior understanding of his or her condition;

(3) *Frequency of treatment*. The frequency of physician-patient visits demonstrates whether the physician has observed the miner often enough to obtain a superior understanding of his or her condition;

(4) *Extent of treatment*. The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition.

20 CFR § 718.104(d)(1)–(4). Moreover, this section provides that a treating physician's opinion shall be accepted "in the absence of contrary probative evidence" and may be given controlling weight if it is credible "in light of its reasoning and documentation, other relevant evidence and the record as a whole." § 718.104(d)(5).

In applying these factors to Dr. Robinette's opinion, I find that there is ample evidence that Dr. Robinette has treated the miner over a five-year period, and seen him with great frequency and regularity. Mr. Smith was referred to Dr. Robinette by Dr. Forehand because of the abnormalities in his chest x-ray, and Dr. Robinette is a pulmonary specialist, and has treated Mr. Smith primarily for his pulmonary and respiratory condition. Dr. Robinette's treatment records reflect that he has diagnosed simple and complicated pneumoconiosis, as well as underlying chronic obstructive pulmonary disease, chronic interstitial fibrosis and granulomatous disease. While the x-rays and CT scans are not determinative standing alone, they offer considerable support for Dr. Robinette's opinion as to all these diagnoses. I find that his opinion

is entitled to the greatest weight because it is credible in light of its reasoning and documentation, and more consistent with the evidence as a whole than Dr. Hippensteel's contrary opinion. Moreover, I note that in Dr. Michos' initial review of the evidence then available in 1998, he recommended that causes other than complicated pneumoconiosis for the large opacity Dr. Forehand viewed on x-ray, such as tuberculosis and a malignancy, be ruled out. Dr. Robinette's records document that he ruled out both causes, and Dr. Hippensteel tested for others with inconclusive results.[8] Dr. Hippensteel conceded that coal mine dust can cause a purely obstructive impairment, and combine with smoking to cause emphysema. He also conceded that pneumoconiosis can co-exist with granulomatous processes. He offered no convincing argument for attributing Mr. Smith's abnormalities to smoking and old granulomatous disease, but ruling out coal dust entirely as a contributor.

I find the opinions of Drs. Robinette and Forehand to be in better accord both with the evidence underlying their opinions and the overall weight of the medical evidence of record. I also find that as Mr. Smith's treating physician, Dr. Robinette's opinion is entitled to the greatest weight. Weighing all of the medical evidence together, I find that the Claimant has established the presence of simple and complicated pneumoconiosis.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. § 921 (c)(1); 20 C.F.R. § 718.203(b) (2003). As Claimant has established 22 years of coal mine employment, he is entitled to the presumption. There is no evidence that rebuts this presumption. I find that the Claimant has established this element of entitlement.

Total Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921 (c)(3), 20 C.F.R. § 718.304 (2003), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 C.F.R. § 718.204(b) and (c) (2003). The Regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion, and (5) lay testimony. 20 C.F.R. § 718.204(b) and (d) (2003). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a

[8] Indeed, the fact that the medical records establish that Mr. Smith had no history of positive PPD tests or active tuberculosis, undermines the negative x-ray and CT scan readings by Drs. Scott and Wheeler, who consistently attributed Mr. Smith's abnormal x-rays and April 1998 CT scan to tuberculosis. Their interpretations are distinguishable from others who merely marked "tb" as the only code on the x-ray reading form consistent with granulomatous disease, as did Drs. Forehand and Hippensteel, because Drs. Scott and Wheeler both specifically identified tuberculosis in their comments.

finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 C.F.R. § 718.204(d) (2003); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). I find that the evidence is sufficient to establish that the Claimant suffers from complicated pneumoconiosis. Moreover, all of the pulmonary function studies, blood gas studies and medical opinions also establish that Mr. Smith has a total pulmonary or respiratory disability.

Causation of Total Disability

In order to be entitled to benefits, the Claimant must establish that pneumoconiosis is a "substantially contributing cause" to the Claimant's disability. A "substantially contributing cause" is one which has a material adverse effect on the Claimant's respiratory or pulmonary condition, on one which materially worsens another respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 C.F.R. § 718.204(c) (2003); *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990); *Bonessa v. U.S. Steel Corp.*, 884 F.2d 726, 734 (3rd Cir. 1989).

The Benefits Review Board has held that Section 718.204 places the burden on the claimant to establish total disability due to pneumoconiosis by a preponderance of the evidence. *Baumgardner v. Director, OWCP*, 11 B.L.R. 1-135 (1986). Nothing in the commentary to the new rules suggests that this burden has changed; indeed, some language in the commentary indicates it has not changed. See 65 Fed. Reg. at 79923 (2000) ("Thus, a miner has established that his pneumoconiosis is a substantially contributing cause of his disability if it either has a material adverse effect on his respiratory or pulmonary condition or materially worsens a totally disabling respiratory or pulmonary impairment …"). The Fourth Circuit requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Hobbs v. Clinchfield Coal Co*., 917 F. 2d 790, 791-792 (4th Cir. 1990). In *Toler v. Eastern Associated Coal Co*., 43 F.3d 109 (4th Cir. 1995), the Court found it "difficult to understand" how an Administrative Law Judge (ALJ), who finds that the claimant has established the existence of pneumoconiosis, could also find that his disability is not due to pneumoconiosis on the strength of the medical opinions of doctors who had concluded that the claimant did not have pneumoconiosis. The Court noted that there was no case law directly in point and stated that it need not decide whether such opinions are "wholly lacking in probative value." However the Court went on to hold:

> Clearly though, such opinions can carry little weight. At the very least, an ALJ who has found (or has assumed arguendo) that a claimant suffers from pneumoconiosis and has a total pulmonary disability may not credit a medical opinion that the former did not cause the latter unless the ALJ can and does identify specific and persuasive reasons for concluding that the doctor's judgment on the question of disability does not rest upon her disagreement with the ALJ's finding as to either or both of the predicates in the causal chain.

43 F.3d at 116. *See also Scott v. Mason Coal Company*, 289 F.3d 263, 269-270 (4th Cir. 2002).

In this case, both Dr. Robinette and Dr. Forehand concluded that Mr. Smith has pneumoconiosis. Dr. Forehand credited the combined effects of smoking and coal dust exposure for Mr. Smith's lung impairment. Dr. Robinette was not asked specifically to give an opinion on causation, and his treatment records do not address the relative roles of coal dust exposure and smoking. Nonetheless, a fair reading of his records establishes that he considered both to be factors, and he repeatedly urged Mr. Smith to stop smoking.

Dr. Hippensteel, on the other hand, was adamant in his opinion that Mr. Smith had neither simple nor complicated pneumoconiosis, and attributed his impairment at first entirely to smoking, and later, somewhat inconsistently, also to old granulomatous disease. Because he based his opinion on causation on the absence of pneumoconiosis, which I have found to be present, I give his opinion little weight. The only other doctor who gave an opinion that pneumoconiosis did not contribute to the disability was Dr. Michos, who was also of the opinion that Mr. Smith did not have pneumoconiosis, based on incomplete information. As I have concluded that the evidence establishes that Mr. Smith has simple and complicated pneumoconiosis, I credit the opinions of Dr. Robinette and Dr. Forehand that pneumoconiosis is a substantially contributing cause to Mr. Smith's disability.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. In this case, the evidence establishes that Mr. Smith has been totally disabled since at least February 1998, when Dr. Forehand administered the earliest available pulmonary function and blood gas studies. The regulation regarding subsequent claims also provides, however, that "In any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final." 20 CFR § 725.309(d)(5). The District Director issued his proposed decision and order on Mr. Smith's prior claim on April 20, 1999. As Mr. Smith took no further action on that claim, it became final one year later, on April 20, 2000. I therefore find that the claimant is entitled to benefits commencing on April 20, 2000.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Having considered all of the relevant evidence, I find that the Claimant has established that he has pneumoconiosis, and a totally disabling pulmonary or respiratory impairment caused by pneumoconiosis. Thus the Claimant has met his burden of showing a change in an applicable condition of entitlement pursuant to § 725.309(d). Accordingly, the Claimant is entitled to benefits under the Act.

ATTORNEY FEES

The Regulations address attorney's fees at 20 CFR §§ 725.362, 365 and 366 (2003). Claimant's attorney has not yet filed an application for attorney's fees. Claimant's attorney is hereby allowed thirty days (30) days to file an application for fees. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The parties have ten days following service of the application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits filed by Noah S. Smith on April 12, 2002, is hereby GRANTED.

A

ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHT: Pursuant to 20 C.F.R. § 725.481 (2003), any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this Decision and Order by filing notice of appeal with the Benefits Review Board, at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.